

Premature Termination of Psychotherapy in Outpatient Clinic Settings: Structural effects of Patients' Expectations, Treatment Tolerance, Therapists' Competencies and Therapeutic Alliance

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Abstract

Objective: A great number of patients leave psychotherapy prior to the end of treatment. The present study predicts the premature termination of individual psychotherapy based on patients' expectations and tolerance and therapists' competencies with the mediating role of therapeutic alliance.

Method: In this descriptive cross-sectional study, 317 patients referred to Mental Health Clinics, Pain Clinics and Substance Use Treatment Centers in Mashhad, Iran were selected by random sampling. The data were collected through Distress/Endorsement Validation Scale, Working Alliance Inventory-Short Revised, the Milwaukee Psychotherapy Expectations Questionnaire, and Outcome Questionnaire. The data were analyzed by SPSS-19 and structural equation modeling with LISREL - 8.80 software.

Results: The examined model indicated good fitness for the data observed (RMSEA=0.02, GFI=0.99, AGFI=0.99, NFI=1, CFI=1, IFI=1, RMR=0.00253, P value=0.90). Psychotherapy expectations ($\gamma=-0.40$) and therapists' competencies ($\gamma=-0.29$) directly influenced the premature termination of individual psychotherapy. Treatment tolerance ($\gamma=-0.17$) directly affected the premature termination of individual psychotherapy. Therapeutic alliance ($\beta=-0.13$) had an impact on the premature termination of individual psychotherapy. Psychotherapy expectations ($\gamma=0.42$) and therapists' competencies ($\gamma=0.54$) significantly influenced the therapeutic alliance, thereby affecting the premature termination of individual psychotherapy.

Conclusions: Psychotherapy expectations, treatment tolerance, therapists' competencies and therapeutic alliance interactively affect the premature termination of psychotherapy and therefore on the health outcomes as a main consequence of intervention. This finding did develop insights into designing the tailored interventions to resolve premature termination and improve the outcomes of psychotherapies. Clinicians must be concerned with these factors in the clinics and healthcare centers to enhance the successful termination of psychotherapy.

Keywords: Psychotherapy, Therapeutic Alliance, Premature termination, Health outcomes

Introduction

The success of psychotherapy in outpatient clinic settings depend on the psychotherapists' competency, patients' clinical features, and the therapeutic relationship (Gamache, Savard, Lemelin, Côté &

Villeneuve, 2018; Allen, Cook, Carson, Interian, La Roche & Alegría, 2017). The successful termination of psychotherapy is leading factor in health outcomes. In fact, health outcomes are those events that emerge as a consequence of an intervention (Paterick, Patel, Tajik & Chandrasekaran, 2017). Furthermore, the effective psychotherapy is leading factor for the relapse prevention in therapeutic contexts (Oraki, 2019; Reneses, Muñoz, & López-Ibor 2009). The premature termination of psychotherapy is a process in which patients leave

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psychotherapy when their problems are not still solved and the treatment goals are not achieved (Kegel & Flückiger, 2015; Huibers et al., 2015). The premature termination and dropout from treatment are high with ranged from 10% to 50% in most psychotherapeutic settings (Kegel & Flückiger, 2015). In the most recent meta-analysis, Swift and Greenberg (2012) found that the weighted dropout rate of adult psychotherapy was 19.7% (18.4%). Patient-related factors, psychotherapist-related factors and therapeutic-related factors directly or indirectly affect the premature termination of psychotherapy (Kröger et al., 2014; Werbart, Annevall & Hillblom, 2019; Wiltink et al., 2016). It is important to study the direct and indirect roles of the factors contributing to the premature termination and outcomes of psychotherapy.

Patients' characteristics such as psychotherapy expectations and treatment tolerance directly and indirectly influence the premature termination of psychotherapy (Swift & Greenberg, 2012; Holtforth et al., 2011). Patients' expectations of psychotherapy have long been considered a common treatment factor for premature termination in psychotherapy (Wiltink et al., 2016). Additionally, addressing the clients' expectations can decrease the rate of premature termination and dropout from treatment (Lopes, Gonçalves, Sinai & Machado, 2015; Smith, Sippel, Rozek, Hoff & Harpaz-Rotem, 2019). Positive expectations of success in treatment are associated with better engagement during therapy, decreased distress, and suitable outcomes (Smith et al., 2019; Lopes et al., 2015). In addition, low treatment tolerance is the main predictor of dropouts, premature termination, and unfavorable psychotherapy outcomes (Reneses et al., 2009). Treatment tolerance involves distress tolerance and treatment endorsement (Deville, 2004). Distress tolerance is defined as the capacity to experience negative psychological states. Furthermore, treatment endorsement includes patient confirmation from treatment agenda and plan (Deville, 2004).

Patients with low treatment tolerance perceive unbearable distress and cannot handle distress or are upset in the process of psychotherapy (Zeifman, Boritz, Barnhart, Labrish & McMain, 2020).

Furthermore, therapists' competencies are influential in the success of psychotherapy in psychiatric and medical settings (Roos & Werbart, 2013; Henzen, Moeglin, Giannakopoulos & Sentissi, 2016). Therapists' competencies contain qualities of clinical practice, specialized knowledge, skills, abilities, and therapeutic characteristics (Webb et al., 2010; Fairburn & Cooper 2011; Weck et al., 2015). Additionally, the most important factor in therapeutic effectiveness and successful termination of psychotherapy is therapeutic alliance (Allen et al., 2017; Kelley et al., 2014). The therapeutic alliance is defined in different ways, the core consensus among these definitions is the alliance that is a mutual collaboration between therapist and client (Uckelstam, Holmqvist, Philips & Falkenström, 2020; Koole and Tschacher, 2016). In sum, the alliance is a positive emotional bond between patient and therapist, their abilities to agree and reach the same goal, and performing congruent tasks during psychotherapy sessions (Allen et al., 2017; Koole & Tschacher, 2016).

Numerous studies have focused on predictors of the premature and successful termination of psychotherapy separately and in a restricted manner in the psychiatric and medical settings. However, few studies have discovered the comprehensive and integrated model, including patient-related factors, therapist-related factors, and therapeutic factors in the prediction of premature termination of psychotherapy. This study was performed based on the theoretical frameworks and the conceptual models outlined by Werbart, Annevall, and Hillblom (2019), Ardito and Rabellino (2011), and Wampold (2015) on prediction of premature termination and psychotherapy outcomes. In this study, premature termination defined based on missed appointments, therapists' judgment,

informed withdrawal and psychotherapy outcome. The fundamental need for evaluating the integrated model of termination of psychotherapy in order to improve psychotherapy and health outcomes in outpatient mental health settings and outpatient healthcare settings highlights the importance of this study. The aim of this study was to find out the premature termination of individual psychotherapy based on patients' expectations and tolerance and therapists' competencies with the mediating role of therapeutic alliance. According to these objectives, Figure 1 presents the hypothetical model based on the theoretical foundations and conceptual models outlined above by Werbart, Annevall, and Hillblom (2019), Ardito and Rabellino (2011), Laferton et al. (2017), and Wampold (2015) regarding direct and indirect effects of psychotherapy expectations, treatment tolerance, and therapists' competencies through the mediating role of therapeutic alliance in the premature termination of individual psychotherapy.

Methodology

In this cross-sectional descriptive study, the statistical population was all the patients having

referred to or attended Mental Health Clinics, Pain Clinics and Substance Use Treatment Centers in Mashhad, Iran. According to the sample size requirements and calculation of model parameters for structural equation modeling analysis (Wolf et al., 2013) as well as recently published studies, 330 patients selected through the convenience random sampling method. The data collected for 13 cases were incomplete or missing and were excluded from the statistical analysis. Thus, the final sample included 317 outpatients in mental health clinics in Mashhad. The diagnosis of the patients included anxiety disorders, depressive disorders, obsessive compulsive disorder, personality disorders, somatic symptom disorder and substance-related disorders that are determined by clinician diagnosis in the patient's clinical record and psychiatric interview in terms of the structured clinical interview for DSM-5 (SCID-5). The inclusion criteria were writing and reading literacy at least on elementary grade, prematurely terminated cases from beginning sessions of individual psychotherapy in the domains of cognitive-behavior psychotherapies (e.g. dialectical behavior therapy and acceptance and commitment therapy),

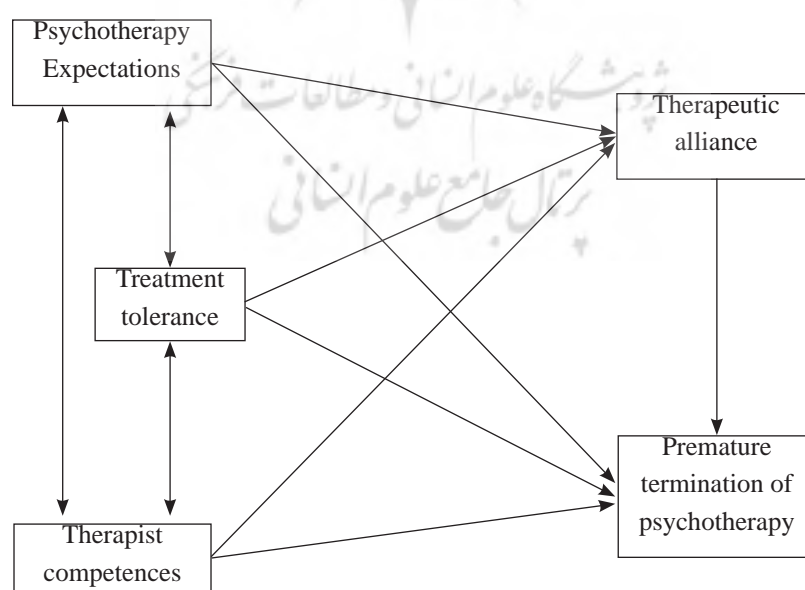


Figure 1. Hypothetical model concerning direct and indirect impacts of psychotherapy expectations, treatment tolerance, and therapists' competencies through the mediating role of therapeutic alliance in the premature termination of individual psychotherapy

psychodynamic psychotherapies (e.g. object relations and short-term dynamic psychotherapy), integrative therapies (e.g. schema therapy), and eclectic psychotherapies (e.g. multimodal therapy and cognitive-analytic therapy) in a past month. The exclusion criteria were pharmacotherapy for the psychiatric disorders due to another medical condition (by psychiatric diagnosis), comorbidity of chronic medical diseases such as cancer and cardiovascular disease (by physician diagnosis), receiving concurrent treatments (by self-report statements and treatment records), receiving other individual psychotherapies, and incomplete instruments in the study.

The present study was conducted in terms of ethical considerations and reviewed by Institutional Review Board and approved by the Ethics Committee of the Psychology Department at Semnan University, Iran with the code of 98.93.739. Furthermore, this study was performed by considering such prominent issues as informed consent to participate in study, confidentiality, and protection of participants' information. Written informed consent was obtained from each participant before participation.

Instruments

The Distress/Endorsement Validation Scale (DEVS): DEVS was developed by Devilly (2004) in 10 items which rated on a 9-point Likert scale ranging from 1 (not at all) through 5 (somewhat distressed) and up to 9 (very distressed). The DEVS has two factors, including distress factor that assesses tolerance for distress in treatment (7 items) and endorsement factor that assesses acceptance of treatment agenda and plan (3 items). The total score ranges from 10 to 90. According to Devilly (2004), the scale has shown high internal consistency in distress factor and endorsement factor, respectively (Cronbach's $\alpha=0.92$ and 0.84). Construct validity, face validity, and content validity were reviewed and approved by five expert

psychiatrists for applying to Iranian samples. In the present research, Cronbach's α for distress factor and endorsement factor were 0.81 and 0.79 , respectively. In addition, the test-retest reliability coefficient during the three-month period was 0.72 .

The Working Alliance Inventory-Short Revised (WAI-SR Client Version): WAI-SR Client Version was developed by Hatcher and Gillaspay (2006). The WAI-SR has 12 items and three subscales of Goal, Task, and Bond that are rated on a 5-point Likert scale in the range of 1 (never) to 5 (always). In this inventory, the scores range from 12 to 60, and higher scores indicated higher therapeutic alliance. The WAI-SR shows good psychometric properties. Internal consistency with Cronbach's α coefficients for the total scale in outpatient and inpatient samples were 0.91 and 0.92 , respectively. Cronbach's α for the subscales of Task, Goal, and Bond in outpatients and inpatients was 0.85 up to 0.90 (Hatcher & Gillaspay, 2006). WAI-SR Convergent Validity with the Helping Alliance Questionnaire was satisfactory ($r=0.64$) and Cronbach's α was higher than 0.80 (Munder et al., 2010). The construct validity, face validity, and content validity of the instrument for use in the Iranian sample were established. In this study, Cronbach's α was 0.92 and the test-retest reliability coefficient during the three month period was 0.74 .

The Milwaukee Psychotherapy Expectations Questionnaire (MPEQ): MPEQ was developed by Norberg et al. (2011). MPEQ has 13 items comprising two factors of expectations of the therapeutic process (treatment) and expectations of therapeutic outcomes. This scale is rated on an 11-point Likert scale ranging from 0 (Not at all) through 5 (Somewhat) and up to 10 (Very). The total score range from 0 to 130 and higher scores indicate higher positive expectations of the process and outcomes of psychotherapy. Both factors demonstrated high internal consistency coefficients ($\alpha>0.85$) and adjusted mean item-total correlation

(0.64 and 0.77) in factors of process and outcomes, respectively (Norberg et al., 2011). One weekly test-retest reliability for the factors of psychotherapy process and psychotherapy outcomes were 0.83 and 0.76, respectively. This scale has construct validity, face validity, and content validity in Iran. In the present study, Cronbach's alpha were 0.92 and 0.91 for the factors of psychotherapy process and psychotherapy outcomes, and the test-retest reliability coefficient during the three month period was 0.69.

The Outcome Questionnaire-45.2 (OQ®-45.2): OQ®-45.2 was developed by Lambert et al (2013) and includes 45 self-reported items. This questionnaire monitors progress in therapy over time, therapy termination and assesses symptom distress (anxiety and depression), impairments in interpersonal relations (satisfaction and problems in relationships), and social role performance (functioning with regard to work, family, and leisure tasks). The questionnaire scores are rated based on a 5-point Likert spectrum ranging from 0 (never) to 4 (always), although some items have reversed scoring. In this questionnaire, the scores ranged from 0 to 180, and higher scores indicate worsened outcomes. Cronbach's alpha and test-retest reliability has been reported to be equal to 0.93 and 0.84, respectively (Lambert et al., 1996). The construct, face and content validity of the instrument were approved in Iran. In this study, Cronbach's alpha for the total scale and the related subscales oscillated between 0.90 and .95 and the test-retest reliability coefficient during the three month period was 0.80.

The Checklist of Therapists' Skills and Competencies in Psychotherapy: This checklist included 29 items utilized to assess the general psychotherapy skills outlined by AADPRT Psychotherapy Task Force and therapeutic abilities of the psychotherapist (Mellman & Beresin 2003; Nelson & Graves, 2011). The present checklist includes essential competencies for therapists in

psychotherapy that were outlined by Manning et al. (2003). This checklist encompasses 7 dimensions of psychotherapy boundaries, therapeutic alliance, listening, psychotherapy-related emotions, understanding, avoidance/resistances/defenses, and techniques of intervention. The items in the checklist are scored based on a 4-point Likert scale from 0 (never) to 3 (always). In this checklist, the scores range from 0 to 87. Higher scores indicate higher levels of therapists' competency. Five experts assessed and approved the construct, face and content validity of this checklist for use in Iran. In the present study, Cronbach's alpha for this checklist was obtained 0.96 and the test-retest reliability coefficient during the three month period was 0.78.

The present study was performed in individual format by trained investigators in allocating rooms in mental health clinics in Mashhad, Iran. The staff of the clinics arranged appointments for the participants. In this study, the treatment context is outpatient units of Mental Health Clinics, Pain Clinics and Substance Use Treatment Centers. The therapists have academic degree in Master of Science or Ph.D. in Clinical Psychology, Health Psychology and Counseling or they are Psychiatrist who all have certificate in clinical supervision and providing psychotherapy services. The data obtained were initially analyzed, using descriptive statistics (mean, standard deviation, frequency, percentile, and correlation) through SPSS-19 software. Subsequently, at the level of inferential statistics, the data were analyzed by structural equation modeling with LISREL-80 software.

Findings

The mean age of the participants was 32.91 (SD=0.50) and their age ranged from 18 to 59 years old. Table 1 shows the background data in this study.

Table 2 provides mean, standard deviation, and correlation matrices of variables, including

Table 1. The background data in the present study

Variable	Classification	Frequency (Percentile)
Patients' Gender	Male	146(46.1%)
	Female	171(53.9%)
Marital status	Single	100(31.5%)
	Married	183(57.7%)
	Divorced	34(10.7%)
Educational level	Diploma and lower	103(32.5%)
	Bachelor's degree	97(30.6%)
	MSc	67(21.1%)
	PhD	50(15.8%)
Treatment accessibility	Appropriate accessibility	215(8.67%)
	Inappropriate accessibility	102(32.2%)
Employment status	Employed	181(57.1%)
	Unemployed	136(42.9%)
Referral source	Without referral source	205(64.7%)
	With referral source	70(22.1%)
Self-reported severity of the problem	Non-specific	42(13.2)
	Mild	133(42%)
	Moderate	76(24%)
	Severe	45(14.2%)
Psychotherapy sessions	Very severe	63 (19.9%)
	1 to 10 sessions	63(19.9%)
	11 to 15 sessions	67(21.1%)
	16 to 20 sessions	80(25.2%)
	21 to 25 sessions	62(19.6%)
	26 to 30 sessions	28(8.8%)
Therapy with medication	More than 31 sessions	17(5.4%)
	Medication with psychotherapy	91(28.7%)
	Only psychotherapy	226(71.3%)
Cost of treatment	\$15 to \$30	189(56.6%)
	\$31 to \$45	32(10.1%)
	\$46 to \$60	59(18.6%)
	\$61 to \$75	38(11.9%)
	More than \$76	9(2.8%)
Duration of treatment	1 month and less	84(26.5%)
	2 to 5 months	142(44.8%)
	6 to 10 months	56(17.7%)
	11 to 15 months	31(9.8%)
	16 months and more	4(1.3%)
Type of psychotherapy	Cognitive behavior psychotherapies	141(44.5%)
	Schema therapy	45(14.2%)
	Dialectical behavior therapy	57(18%)
	Acceptance and commitment therapy	39(12.30%)
	Psychodynamic psychotherapies	53(16.7%)
	Object relations therapy	26(8.2%)
	Short-term dynamic psychotherapy	27(8.5%)
	Eclectic psychotherapy	123(38.8%)
	Multimodal therapy	63(19.9%)
	Cognitive-analytic therapy	60(18.9%)
Type of psychopathology	Anxiety disorders	82(25.8%)
	Depressive disorders	88(27.7%)
	Obsessive compulsive disorder	35(11.1%)
	Personality disorders	42(13.3%)
	Somatic symptom disorder	41 (12.9%)
	Substance-related disorders	29 (9.2%)
Specialty and grade of therapists	MSc in Clinical Psychology/Health Psychology	88(27.8%)
	MSc in Counseling	47(14.8%)
	Ph.D in Psychology/Clinical Psychology/Health Psychology	117(36.9%)
	Ph.D in Counseling	21(6.6%)
	Psychiatrist	44(13.9%)
Therapists' gender	Male	159(50.2%)
	Female	158(49.8%)

Table 2. The correlation between variables, mean, and SD

Variables	M±SDa	Correlation' coefficients			
		1	2	3	4
1.Therapeutic alliance	34.70±0.60				
2.Premature termination of psychotherapy	95.75±2.03	-0.70*			
3.Psychotherapy expectations	59.94±1.26	0.73*	-0.72*		
4.Treatment tolerance	40.15±0.74	0.61*	-0.64*	0.63*	
5.Therapist competencies	59.38±1.95	0.74*	-0.72*	0.73*	0.62*

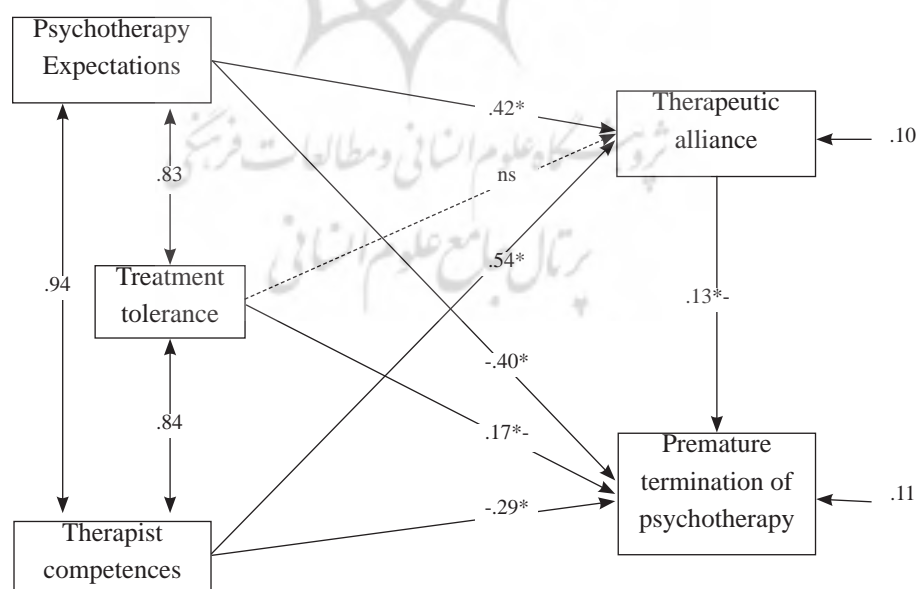
*p<0.01; a. M=mean, SD=standard deviation

treatment alliance, premature termination of psychotherapy, psychotherapy expectations, therapeutic tolerance, and therapists' competencies.

According to Figure 2, structural equation modeling specifies treatment tolerance through therapeutic alliance and has no effect on the premature termination of psychotherapy; however, other paths are significant. Fitness indices suggest that the modified final model has a good fitness with the data. In Figure 2, the modified final model is presented.

Structural equation modeling (Figure 2) shows that the biggest path coefficient in the model was the impact of the therapists' competencies on therapeutic alliance ($p<0.01$, $\gamma=0,54$). In addition,

the lowest path coefficient in the model (Figure 2) was the impact of the therapeutic alliance on the premature termination of psychotherapy ($p<0.01$, $\beta=-0.13$). The path coefficient of the impact of psychotherapy expectations on premature termination of psychotherapy was significant ($p<0.01$, $\gamma=-0,40$). Psychotherapy expectations indirectly affect the premature termination of psychotherapy via impacts on therapeutic alliance. The path of psychotherapy expectations on therapeutic alliance is significant ($p<0.01$, $\gamma=0,42$), which in turn influences the premature termination of psychotherapy ($p<0.01$, $\gamma=-0.13$). The path coefficient of the impact of treatment tolerance on the premature termination of psychotherapy



Chi-Square=1.04, df=4, P-value=0.90402, RMSEA=0.020

Figure 2. Examined model of structural relations between psychotherapy expectations, treatment tolerance, and therapists' competencies with the mediating role of therapeutic alliance in the premature termination of individual psychotherapy. Note: ns=non-significant

Table 3. Fitness indices of the examined model

Fit indices	X ²	df	X ² /df	RMSEA	CI (90%)RMSEA	GFI	AGFI	NFI	CFI	IFI	RMR	P value
Criterion	P>.05	3-5	<.05	<.07	>.90	>.95	>.95	>.95	>.95	>.95	>.0	<.05
Examined model	1.04	4	.26	.02	(.01;.10)	.99	.99	1	1	1	.00253	.90

Note. RMSEA: Root mean square error of approximation; GFI: Goodness of fit index; AGFI: Adjusted GFI; NFI: Normed fit index; CFI: Comparative fit index; IFI: Incremental fit index, RMR: Root mean square residual

was ($p < 0.01$, $\gamma = -17$). The path coefficient of therapists' competencies on the premature termination of psychotherapy was significant ($p < 0.01$, $\gamma = -0.29$). Moreover, the path coefficient of therapists' competencies on therapeutic alliance was significant ($p < 0.01$, $\gamma = 0.54$). Table 3 indicates the fitness indicators of the examined model.

In the structural equation model, the fit indices indicated the model fitness. The indices of χ^2 , df, P value, and RMSEA are the best indices in the LISREL software, and χ^2/df value is 0.26 in this model. The RMSEA values less than 0.08 indicate acceptable fitness. Additionally, CFI, NFI, GFI, and AGFI equal or higher than 0.95 indicate good model fit (Hipp & Bollen, 2003). The value of RMSEA in the model was .02 which is a very good value. The P value index in the present study was 0.90 and significant in the 99% confidence interval ($p < 0.01$). The value of NFI and CFI indices in the present study was 1. These two indices can be located between 0 and 1. NFI and CFI with values closer to 1 have better fitness (Hipp & Bollen, 2003). The value of RMR index in the present study was 0.00253. When the value of this index

is more than zero, it is acceptable. Therefore, the value of RMR in the present study is acceptable. The value of GFI and AGFI indices in the present study was 0.99. GFI and AGFI values closer to 1 have better fitness. In addition, the value of IFI index was 1, suggesting that it is a very good value. Table 4 demonstrates direct, indirect, and total effects of predictors on the premature termination of psychotherapy.

According to the total effects (Table 4), the highest total direct effect is related to the impact of therapists' competencies on therapeutic alliance ($\gamma = 0.54$). Furthermore, as Table 4 indicates, the lowest total direct effect is related to the impact of endogenous variables (therapeutic alliance) on premature termination of psychotherapy ($\beta = -0.13$).

Discussion and conclusion

Structural equation modeling indicated that psychotherapy expectations, treatment tolerance, and therapists' competencies had direct effects on the premature termination of psychotherapy in outpatient clinic settings. Moreover, psychotherapy expectations and therapists' competencies had

Table 4. Direct, indirect, and total effects of psychotherapy expectations, treatment tolerance, therapists' competencies, and therapeutic alliance on premature termination of psychotherapy

Impact	Path	Direct Effect	Indirect Effect	Total Effect
Exogenous on Endogenous	Psychotherapy expectations on premature termination of psychotherapy	-0.40	-0.05	-0.45
	Treatment tolerance on premature termination of psychotherapy	-0.17		-0.17
	Therapists' competencies on premature termination of psychotherapy	-0.29	-0.07	-0.36
	Psychotherapy expectations on therapeutic alliance	0.42		0.42
	Therapists' competencies on therapeutic alliance	0.54		0.54
Endogenous on Exogenous	Treatment tolerance on therapeutic alliance	-	-	-
	Therapeutic alliance on premature termination of psychotherapy	-0.13		-0.13

indirect effects on the premature termination of psychotherapy through the mediating role of therapeutic alliance. These findings are consistent with some similar studies (Kegel & Flückiger, 2015; Swift & Greenberg, 2012; Goldsmith et al., 2015). Holtforth et al. (2011) concluded that psychotherapy expectations directly play an important role in premature termination of psychotherapy. Kröger et al. (2014) argued that constructive psychotherapy expectations are highly influential factors in effective treatment processes and successful termination of psychotherapy. As Lopes et al (2018) explain, it can be argued that patients' expectations of psychotherapy sessions strongly predict the treatment outcomes. In addition, responding to the expectations of clients is an important determinant of future referrals to counseling and psychotherapy centers in Iranian culture. Accordingly, patients with destructive psychotherapy expectations have much higher rates of adverse outcomes and premature termination of treatment. Moreover, in this study consistent with study by Swift and Greenberg (2012), psychotherapy expectations indirectly affect the termination of psychotherapy through the therapeutic alliance.

Consistent with previous studies (Zeifman et al. 2020 and Kröger et al. 2014), this study indicated that treatment tolerance directly affects premature termination and outcomes of psychotherapy. It can be argued that patients with a higher tolerance capacity to distress and therapy burden have the ability to admit principles and rules of psychotherapy and get greater benefits from psychotherapy. In addition, consistent with cultural issues, this implies that, given the continuing psychological challenges for those seeking mental health services in Iran, patients with higher tolerance are able to end treatment. In this model, based on the structural equation analysis, the indirect effect of treatment tolerance on premature termination of psychotherapy through therapeutic alliance was not significant. This finding is inconsistent with what

Kröger et al. (2014) and McHugh et al. (2014) found. Concerning these inconsistent results, it can be argued that different methodologies, different conceptualization and assessments, and various cultural formations can lead to incongruous results in such studies.

Webb et al. (2010) and Weck et al. (2015) also inferred that the therapists' competencies directly and indirectly influence the successful termination and favorable outcomes of psychotherapy through fostering the therapeutic alliance. Weck et al. (2015) assumed that better competencies, therapeutic skills, and techniques for more specialized interventions satisfy patients' therapeutic needs and result in the successful termination of psychotherapy. In explaining this finding, it can be concluded that in Iranian culture, the patient's view of the competencies of therapists or the efficacy of therapists is a key factor in referring and continuing psychotherapy sessions. Finally, structural equation analysis in this study was in accordance with Allen et al.'s (2017) and Kelley et al.s (2014), showing that the therapeutic alliance predicts premature termination and dropout from psychotherapy. As Koole and Tschacher (2016) argued, the therapeutic alliance is the link between the beginning of the treatment and the outcomes of the psychotherapy. In addition, Kelley et al. (2014) concluded that patient-clinician relationship has a significant effect on recovery and healthcare outcomes. Factually, therapeutic alliance is an important factor for permanent changes in treatment processes. Furthermore, Anderson, Bautista & Hope (2019) explained that the impact of therapeutic alliance on the outcomes of treatment is related to the effects of this factor on the other factors of successful outcomes of therapy.

Based on goodness of fit indices in this research model, the data collected had a good fit with the data observed. The new finding of the present study will approve the integrated model of a successful termination and favorable outcomes of

psychotherapy in outpatient mental health services in the fields of Psychiatry, Clinical Psychology and Health Psychology. This study encountered particular restrictions. First, the cross-sectional study restricts the inference of causality between factors. Second, convenience sampling method restricts the generalization of the findings. Third, utilizing self-reported instruments may have influenced these results. Fourth, in this study, patients with comorbid serious medical diseases were excluded. Consequently, generalization of the findings in these patients was restricted. Fifth, patients who received eclectic, cognitive-behavioral, and psychodynamic psychotherapies constituted a segment of the sample of the present study. Accordingly, generalization of results to patients who receive other kinds of psychotherapy should be considered with caution.

This study is among the first studies in the field of treatment outcomes based on integrated and comprehensive perspectives. This study introduces key messages for mental health practitioners and provides desirable knowledge and recognition of the leading factors involved in premature termination of psychotherapy in outpatient clinics and community healthcare centers. Concerning the implications of this study, fostering the clinicians' competencies, improving patients' expectations of therapy, removing discrepant expectations, promoting patients' distress tolerance and enhancing therapeutic alliance are the leading factors for gaining the benefits of psychotherapy that in turn result in proper outcomes and appropriate termination of treatment. It is suggested that researchers consider the role of other factors in premature termination of psychotherapy such as type of therapy, type of diagnosis, serious medical comorbidity and a host of client variables in other communities. It is also recommended that future research in this field focus on patients with various disorders, especially those with severe psychiatric disorders, chronic disease and serious health

conditions.

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